

CONNECTICUT VALLEY HOSPITAL OPERATIONAL PROCEDURE MANUAL

SECTION I:	PATIENT FOCUSED FUNCTIONS
CHAPTER 2:	Provision of Care, Treatment and Services
PROCEDURE 2.42:	Responding to a Choking Episode/Swallowing Episode
REVISED:	02/02/07; 12/10; 02/10/12; 03/12/12; 1/16; 12/19/16; Reviewed 02/18
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PURPOSE: The procedure listed below is to ensure patients at Connecticut Valley Hospital (CVH) can eat with reduced risks of choking and aspiration; while enjoying the least restrictive diet. This will help support patients in maintaining good health, nutrition, and hydration.

SCOPE: All clinical staff.

Criteria:

To determine if a patient is appropriate for a swallowing referral; one more of the following factors are to be present:

1. The patient is not tolerating current diet consistency as indicated by coughing, gagging or choking.
2. The patient has pneumonia or a recent history of recurrent pneumonia.
3. The patient has signs and symptoms of aspiration when eating or drinking.
4. The patient has had a change in medical status that may warrant a possible upgrade or downgrade in diet consistency.

PROCEDURE:

In the event that a patient should have a choking/swallowing episode, the following actions will be taken:

1. The choking/swallowing episode will be immediately reported to the RN followed by a progress note describing the episode. RN will notify the Physician/APRN and request an order for a Swallowing Assessment from Speech Pathology. The Referral for Speech-Language Pathology Services Form [CVH-604](#) (located at [T:\Forms\HIM\Speech Language Pathology Forms\Speech-Lang Referral.604.doc](#)) will be completed by the RN and faxed to Speech Pathology at x7115.
2. Upon completion of the Swallowing Assessment, the Speech Language Pathologist (SLP) will verbally report the recommendations to the charge nurse who will notify the Physician /APRN for orders. The SLP will file the assessment in the assessment section of the chart, and a note in the progress notes containing recommended diet consistency and any swallowing precautions.
3. The SLP will document on the Ambulatory Care Services Medical Rounds Communication form that the assessment has been completed, and attach the assessment to the Medical board for review.

4. The SLP will enter diet change and any swallowing precautions into the treatment plan following written diet order from Physician/APRN.
5. If a patient should become non-compliant with their diet recommendations, they may be more at risk for choking and/or aspiration. Based on the diet order, Nursing will provide patient education regarding the risks of aspiration or choking when non-compliant with the diet order. Nursing will also assist/educate patients to identify foods of the appropriate diet consistency.
6. The Ambulatory Care Clinician completes the medical risk assessment in the Risk Management and Notification System (RMANS) for newly admitted patients, and as indicated for significant changes in condition. This is the mechanism for alerting the treatment team to medical risks, including the risk for choking, and ensures that interventions are put in place to mitigate the risk. (See [*Operational Procedure 5.6 Risk Management*](#)).

Discharge/Termination from Swallowing Treatment:

The patient is discharged from treatment when the patient has achieved one of the following criteria:

- a. Patient is tolerating least restrictive diet with no overt signs and symptoms of aspiration or choking.
- b. The patient's nutritional and hydration needs are optimally met by alternative means.